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SUBSTANCE ABUSE AND PUBLIC POLICY

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SUBSTANCE ABUSE AND PUBLIC POLICY*

ISSUE DEFINITION

Policies and practices related to substance abuse in Canada have grown since the first small piece of federal legislation in 1908, which was directed at opium smokers. Efforts to prevent, treat and control substance abuse now also focus on tobacco, alcohol, solvents, and prescription and over-the-counter drugs and encompass prevention, treatment and enforcement.

At the federal level, the five-year National Drug Strategy launched in May 1987 signalled the high level of concern over abuse of illegal drugs in Canada, a concern driven to a large extent by the "War on Drugs" in the United States. By 1992, the focus of the Strategy had widened to include legal drugs such as alcohol. While continuing the enforcement endeavours of its predecessor, the new Strategy emphasizes prevention of substance abuse and reduction of harm to users.

This review examines substance abuse policy in Canada with respect to both legal and illegal drugs. It provides a general profile of various substances that are abused or misused, including alcohol, tobacco and prescription drugs. Where possible, it assesses the health and social implications of substance abuse, as well as its social and economic costs. While acknowledging the difficulties of determining the nature of drug dependency, the paper describes initiatives aimed at reducing the harm this causes and at controlling the problem through interventions involving education and prevention, treatment and rehabilitation, enforcement and controls.

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* The original version of this Current Issue Review was published in December 1994; the paper has regularly been updated since that time.

BACKGROUND AND ANALYSIS

A. Federal Policy on Drugs

The initial 1987 National Drug Strategy emerged from concern about the abuse of illegal drugs in Canada; however, during its five-year existence, the high social and economic costs attributable to misuse of legal substances also came to be recognized. When a national consultation process explored the impact of Canada's Drug Strategy (CDS) and the Strategy Against Driving While Impaired (SADWI) in 1991, the participants almost unanimously identified alcohol abuse as the biggest problem. Tobacco use was identified as needing greater attention. A second concern was the abuse of pharmaceuticals, both prescription and over-the-counter. Street drugs including cannabis, heroin and cocaine were also a significant problem across the country, however, solvents and inhalants being of particular concern in northern areas.

In 1992, the strategy, now called Canada's Drug Strategy, was renewed and combined with the Driving While Impaired (DWI) Strategy. The continued objective was to reduce the harmful effects of substance abuse on individuals, families and communities by addressing both supply and demand. Coordinated by the Department of National Health and Welfare, the Strategy involved several other departments seeking to enhance existing programs and to fund new ones. Of the $210 million allocated to the initiative, 70% was directed to reducing the demand for drugs through prevention, treatment and rehabilitation and 30% to enforcement and control.

Other policy actions, such as the development of mandatory testing programs for substance abuse in the Department of National Defence and federally regulated transportation sectors, drew attention to the implications of drug use in the workplace while the Tobacco Demand Reduction Strategy focused on the wider implications of use of legal substances.

B. Substance Abuse: What Is It?

Substance abuse can be defined as any use of a substance, non-medical or medical, that causes physical or social harm. Substances can be legal, like alcohol and tobacco, or illegal, like cocaine and heroin. Prescription and over-the-counter drugs can also be misused.

The most abused of all drugs are those that change the way a person thinks, feels or acts, "psychotropic drugs." Many such drugs are prescribed in Canada each year to relieve pain, to calm nervousness, or to aid sleep. Some, like alcohol and nicotine, are available for purchase without prescription. Others, including cannabis and cocaine, are prohibited under criminal law and can only be obtained illegally.

While the exact percentage of the general population misusing or abusing substances is difficult to ascertain, in surveys carried out in conjunction with Canada's renewed Drug Strategy 2.8 million Canadians reported having a family member with a drug problem. Although substance abuse can affect any Canadian regardless of sex, age, ethnic origin, educational level, or employment status, it seems that certain groups are more at risk. At all ages, men are more likely than women to use illegal drugs, while women are more likely to use prescription drugs that could lead to dependency. Young adults are more likely than older people to use illegal drugs but older people are more likely to have multiple drug prescriptions.

Groups in which abuse of drugs is prevalent include street youths and some aboriginal people. In federal prisons, almost seven out of ten offenders have alcohol or other drug problems severe enough to warrant formal intervention. In all these groups, the negative physical and social effects are profound.

Consumption of illegal drugs in Canada has stabilized or declined since 1977, however, when it was first measured. Moreover, the vast majority of people who report having used illegal drugs do not continue using them throughout their lives. **In 1994, 23.1% reported having used cannabis but only 7.4% were current users. Cocaine or crack had been used by 3.8% but only 0.7% were current users. Similarly, 5.9% reported having used LSD, speed and/or heroin, but only 1.1% were still using it. Of the 7.7% of Canadians who reported injecting drugs, 41% had shared needles at some time.**

Despite the undoubted physical harm to individual abusers of alcohol and the social damage to them, their families and their communities, debate continues on the beneficial versus the harmful effects of alcohol consumption. Some studies have found that various forms of heart disease are less common among light to moderate drinkers than among abstainers and heavy

drinkers and suggest that alcohol, if used in moderation, may actually produce health benefits. On the other hand, there is evidence that for some individuals even moderate drinking may lead to a need for expensive medical treatment and rehabilitation programs. This conflicting information presents a dilemma for governments seeking to develop sound public health policy.

C. Why Do People Become Dependent on Drugs?

Another difficulty in developing sound public policy in this area is the lack of consensus on the nature of drug dependence: why do some individuals exhibit a compulsive pattern of drug use leading to addiction while others can use the same drugs occasionally without developing such dependence? Because of difficulty with data collection, most of our knowledge about the effects of drugs is based on observations of cases where dependency has led to overdoses or to criminal activity. There is much less information about individuals who use drugs without dependency.

A discussion of drug use can adopt a medical, psychological, sociological, economic, legal, criminological, pharmacological or philosophical approach. Thus it can simultaneously attribute addiction to a genetic component (for example, an inherited susceptibility for alcoholism); an addictive personality type (that easily becomes dependent on everything from coffee to cocaine); critical environmental circumstances (that can determine an individual's behaviours and health); and, more recently, certain brain cells that create a craving for particular substances.

Drug dependence is most commonly categorized in two ways, neither of which is deemed adequate as a full explanation. The problem can be seen as either a psychological failure of character or as a physiological failure of health. The first has been characterized as the moral failure model (drug dependence as sin) and the second as the disease model (drug dependence as sickness). The first categorization places the full responsibility of drug consumption on the individual, who is assumed to have made a free choice between moral and immoral behaviour. The second presumes that the dependent person is suffering from a disease.

Still others suggest a sociological explanation of substance abuse and argue for a shift to a health and socio-economic determinants model. Good health is today seen as relating to a person's economic status, age, gender, occupation, ethnicity and geographical location. Certain groups, including males, the unemployed, aboriginal peoples, and street youth, have been identified as having a higher chance of becoming dependent on drugs. Greater understanding of the predisposing factors can assist in preventing and treating the dependency.

D. What are the Substances and the Consequences of Abuse?

The following section describes various legal and illegal substances using data from national and provincial surveys and legal statistics to highlight general trends in their abuse and some health and legal implications.

1. Legal Substances

a. Alcohol

Alcohol consumption continues to decline. The percentage of Canadians over 15 years of age reporting themselves to be current drinkers declined from 81% in 1985 to 74.4% in 1993. Drinkers were more likely to be young men in their early twenties with a post-secondary education and higher than average income. Alcohol consumption by youth under the legal drinking age is not easy to assess but it is estimated that three in four students (75%) under drinking age have used alcohol.

In 1990-91, there were 38,261 recorded alcohol-related hospital separations in Canadian mental and general hospitals; men accounted for 71.2% of these cases. The median age of those receiving treatment for an alcohol-related problem was 46.9 years. Associated with alcohol were conditions such as alcoholic dependence syndrome, chronic liver disease and cirrhosis, alcoholic gastritis, and alcoholic cardiomyopathy.

Of the deaths directly attributable to alcohol, cirrhosis and other liver disease accounted for 69.1%. Deaths indirectly attributable included homicides, motor vehicle accidents, accidental falls, suicides, and diseases of the respiratory and circulatory systems. In 1991, the

estimated overall number of deaths directly and indirectly attributable to alcohol increased slightly from 1990. Impaired driving remained the major cause of death for young people.

The control and sale of alcohol is regulated by each province, while drinking and driving offences fall under federal legislation. In 1992, 65% of the offences reported under provincial statutes (excluding traffic offences) were liquor-related. Across Canada, the number of federal drinking and driving offences has generally been declining, but there were still 597 offences per 100,000 population aged 16 or older in 1992. About 91% of the drinking and driving offences were for impaired operation of a motor vehicle; 8% for failure or refusal to provide a breath or blood sample; and 1% for impaired operation causing bodily harm or death. From 1990 to 1992, of the adults charged in any given year with either provincial or federal offences, 91% were male.

b. Tobacco

In 1994, the Drug Abuse Advisory Committee of the U.S. Food and Drug Administration (FDA) reported mounting scientific evidence that cigarettes and other tobacco products were addictive; nicotine was confirmed as the drug in tobacco causing addiction. In the same year, Health Canada announced that it was designing a study to measure nicotine levels in cigarettes between 1968 and 1995. The results released in June 1995 indicated that the level of nicotine in tobacco used in cigarettes has increased by 53%.

In 1965, almost 50% of Canadians stated that they smoked. By 1990, 29% of respondents to the Health Promotion Survey indicated that they did so while 35% said that they had stopped smoking. At the same time as the proportion of smokers was decreasing, so was the level of consumption of those who continued to smoke. The high-volume daily smoker was characterized as likely to be middle-aged, well-to-do and college educated.

In 1994, Health Canada in conjunction with Statistics Canada undertook a four-cycle longitudinal survey to track smoking prevalence and the amount smoked daily by about 12,000 Canadians aged 15 and over. In February 1995, 27% of people reported that they smoked,

down from 30% in May 1994. The 20-24 age group continued to have the highest prevalence of smoking, at 34% overall. Of daily smokers, males smoked somewhat more than females.

This estimate was based on the number of deaths due to chronic bronchitis, asthma and emphysema and on 30% of all deaths due to neoplasms, stroke, hypertension and heart disease.

c. Solvents

Collection of data on solvents use in Canada is limited. In 1990 and 1992 surveys of Toronto and Halifax street youth, between 8% to 15% of respondents reported the use of solvents in the past year. This contrasts with the findings for the general Ontario student population, where the Ontario Addiction Research Foundation found a slight increase of sniffing of glue and other solvents, from 1.6% of those surveyed in 1991 to 2.3% in 1993.

Recent media stories have pointed out that solvent abuse is a major problem among young aboriginal people. The 1993 First Nations and Inuit Community Youth Solvent Abuse Survey indicated that solvent users were most often males between 12 and 19 years of age. The majority of young people use solvents to experiment (42.3%) or for social reasons (37.5%).

The characteristics of solvent users include: poor socio-economic background, low educational level and troubled family circumstances. The health problems associated with solvent abuse are not well documented but include respiratory difficulties, liver and kidney disturbances, blood abnormalities and nervous system damage.

d. Prescription Drugs

In 1993, the General Social Survey collected data on five categories of prescription drugs: sleeping pills, tranquillizers, diet pills and stimulants, antidepressants, and narcotic pain relievers. While prescription drug use of tranquillizers and sleeping pills increased with age for both men and women, across all age groups women tended to use all categories of prescription drugs more than men. Regionally, narcotic use was highest in British Columbia, and sleeping pill and tranquillizer use was highest in Quebec.

A 1992 Quebec study examined prescribing patterns for elderly people. Of the three drug groups most commonly implicated in drug-related illnesses (psychotropic, cardiovascular and nonsteroidal anti-inflammatory), high-risk prescribing was most prevalent for psychotropic drugs.

In general or psychiatric hospitals, the coding system used for data collection does not distinguish between drug-related problems caused by misuse of legal prescription drugs and those caused by use of illegal drugs. In 1990-91, 33.5% of all drug-related separations from general and psychiatric hospitals were for mental disorders such as drug dependence syndrome and psychoses; the remaining were for poisonings involving prescription drugs. Overall, male patients were more likely to have drug-related mental disorders while female patients were more likely to have poisoning-related conditions.

Thefts and forgeries involving drugs controlled under the *Narcotic Control Act* and the *Food and Drugs Act* decreased in 1993; pharmacies continued to be the most usual target. There was also a reported decrease in the number of prescription forgeries, of which codeine prescriptions continued to account for almost half.

2. Illegal Substances

a. Cannabis

When smoked or ingested, cannabis produces a short-term euphoric effect. High doses can cause perceptual distortion, disorganized thoughts and mild hallucinations. It is difficult to ascertain whether cannabis is addictive and the rate of serious adverse reactions to cannabis in the general population has not been fully determined. However, smoking of cannabis is associated with an increase in respiratory tract conditions.

In 1990, just over one million Canadians, or 5% of the population over the age of 15 years, reported use of cannabis. This represents a decline in use from the 1980s. By 1993, only 4.2% reported current use. The highest reported use was 9.7% among the 20-24 year olds. While 6% of the British Columbia population reported current use in 1993, the percentage of users in other provinces was between 2% and 5%. A 1993 Ontario study reported that 12.7% of students in grades 7, 9, 11 and 13 confirmed experimentation with cannabis at least once in their

lifetime. In a 1994 Alberta report, 19.3% or about one in five adolescents stated that they had experimented with the drug.

Cannabis use has been associated with the use of both tobacco and alcohol. A 1985 study indicated that cannabis users were twice as likely as non-smokers to smoke cigarettes daily and were more likely than non-users to drink alcohol during any given month.

In 1992, cannabis offences accounted for 60% of all drug offences. About two-thirds of the convictions for cannabis were related to possession; for example, in 1992, of about 24,000 cannabis charges, almost 17,000 were for possession.

b. Cocaine

Cocaine, a powerful, short-acting, central nervous system stimulant, can be inhaled, smoked or injected. Clinical studies of heavy cocaine users indicate that few experience the severe withdrawal symptoms associated with physical addiction; in one study, about 8% required treatment. Repeated use did, however, lead to strong psychological craving and consequent dependence.

In 1990, 1% of the population reported being current cocaine users while an additional 2% were former users. Users tended to be males in the 25 to 34 age group. By 1993, only 0.3% reported use of cocaine in the past year.

In 1992, cocaine offences accounted for 24% of all drug offences.

c. Heroin

Heroin is a narcotic analgesic derived from morphine. The preferred mode of administration is injection. Tolerance develops rapidly with regular use. The risk of death from overdose is great, due to the varying quality of the drug. There is also a risk of transmittal of AIDs or hepatitis through shared needles.

After a steady increase from 1988 to 1991, offences involving heroin declined in 1992, representing 2.2% of total drug offences.

E. The Costs of Substance Abuse

As suggested earlier, individuals dependent on substances are more at risk for a range of health problems. In addition to the long-term health problems associated with substance abuse, immediate crises can arise if the amount of drug consumed is misjudged, the drug is contaminated or too strong, or several substances are taken in combination.

The social costs are numerous. Substance abuse can lead to family breakdown when members are unable to maintain close relationships or to alter their personal lifestyle to accommodate others. Young people in aboriginal communities, the poorest of Canada's poor, can feel a hopelessness and despair that leads them to withdraw from their community, to abuse substances and sometimes to commit suicide.

In the workplace, tardiness, constant absences and inability to work may result from intoxication or drug-induced apathy. Reduced productivity may lead to unemployment with all its associated social and health costs. Those addicted to substances have a higher rate of unemployment than average and the unemployed report more use of drugs, including alcohol, than the general population.

Law enforcement costs are incurred by drug abuse; more policing is required to ensure adherence to laws controlling the manufacture and distribution of certain drugs and because some substances produce extremely violent or verbally abusive behaviour. For example, the Alberta Alcohol and Drug Abuse Commission reported that alcohol was involved in about 80% of the provinces' cases of spousal violence. It has also been reported that more than half of the individuals given penitentiary sentences since 1990 were using drugs or alcohol on the day they committed their crime.

In 1996, the Canadian Centre on Substance Abuse completed a major assessment of the costs associated with substance abuse. It concluded that, in 1992 in Canada, substance abuse cost more than $18.45 billion. This amounted to $649 for every Canadian and was equivalent to 2.7% of the Gross Domestic Product. Productivity losses from illness and premature death accounted for $11.78 billion, or 64% of all costs. The

cost to the health care system was more than $4 billion and to law enforcement another $1.76 billion. The Centre estimated that there were 40,930 deaths attributable to substance abuse in 1992, representing 21% of the total mortality for that year.

The CCSA estimate, which used a cost-of-illness approach, is considered to be both more conservative and more accurate than previous estimates. The direct expenses included health care costs such as those for hospital and agency treatment, professional fees, ambulance services and prescription drugs; losses associated with workplace Employee Assistance Programs and drug testing; administrative costs for transfer payments such as social welfare, workers' compensation, and other insurance; costs for prevention and research; costs of law enforcement such as those for police, courts, corrections and customs and excise; as well as other direct costs such as those for fire damage, traffic accidents, and reduced property values in drug-ridden neighbourhoods. Indirect costs included productivity losses due to absenteeism, mortality, and crime.

When individual substances are considered, tobacco accounts for more than half of the total costs at $9.56 billion, alcohol for 40% of costs at $7.52 billion, and illicit drugs for 7% at $1.37 billion. In each case, the largest economic cost is for lost productivity due to illness and premature death. This study did not calculate the cost of misuse of prescription drugs.

F. What Measures Are Currently Used to Address Substance Abuse?

Canada's Drug Strategy was designed to reduce the demand for substances and the resulting social, medical and economic costs through combining measures aimed at education and prevention with those aimed at treatment and rehabilitation and those aimed at control and enforcement. In addition, the three-year Tobacco Demand Reduction Strategy was initiated in 1994 to reduce tobacco consumption through legislation, research, and public education.

1. Education and Prevention

Various efforts to prevent misuse of substances deemed harmful are in place across Canada. Of the respondents to the 1989 National Alcohol and Other Drugs Survey, 80% favoured stronger government intervention through education and prevention programs. Such programs currently aim to help people avoid the use of harmful substances and to enhance their ability to control their use. Education, motivation, and awareness-building are combined with regulation and taxation to achieve the goals, recognizing that different groups have different needs in relation to prevention of substance abuse.

As Canada's 1990 Health Promotion Survey and other studies show, youth and young adults have the highest rates of alcohol, tobacco and marijuana use. As a group, young people require a particular focus if they are to be encouraged to avoid the associated health risks. Such measures as increasing the price of alcohol and cigarettes, creating more smoke-free and alcohol-free environments, and limiting advertising of tobacco and alcohol products encourage young people to make healthy choices; offering greater support to reduce stress is also viewed as essential.

The U.S. Surgeon General reported in 1994 that most smokers become addicted to nicotine before age 18. Children tend first to try cigarettes in the years between 11 and 14 and within a few years may become regular smokers. Governments across Canada have responded to this evidence by developing a multi-faceted approach to discourage teenagers from taking up the habit. Examples of this approach are education programs in school and in the media, warning labels on packages, consideration of plain packaging, and prohibiting smoking in educational, workplace, recreational, and public settings.

Many street workers feel that mainstream addiction programs do not fully respond to the problems faced by people who live on the streets, especially the young. As a result, the City of Toronto in 1990 funded a Drug Abuse Prevention store-front operation, and the Anishnawbe Health Centre provides workers to help indigent aboriginal people. **The YWCA Crabtree Corner in Vancouver's downtown eastside targets high risk families and provides emergency child care as well as referrals, advocacy and counselling.**

The Canadian Coalition on Medication Use and the Elderly has drawn attention to the fact that, while seniors make up only 11% of Canada's population, they use 25% of all prescription drugs; 19% of hospital admissions for people over 50 years of age are related to the improper use and side effects of prescription drugs. Older people may deliberately misuse drugs as a result of stress, anxiety, loneliness or a perceived inability to cope. But misuse can also result from over-prescribing by physicians, lack of monitoring by pharmacists, limited supervision by caregivers, poor communication between health professionals and patients, and inadequate follow-up. Educating physicians to take greater care in prescribing and involving pharmacists to identify unnecessary drugs or drugs that react badly with other medication is seen as a good preventive measure.

Needle exchange programs provide health professionals with the opportunity to offer treatments but are aimed primarily at harm reduction. By offering clean needles to addicts it is hoped to discourage their common practice of sharing dirty needles when injecting drugs. Some of the existing outreach programs involving needle exchange date from 1989, when the spread of AIDS among intravenous drug users became a major concern. Situated in mobile as well as stationary units, these programs deliver community-based and cost-effective prevention. When the British Columbia government's cost-cutting measures threatened the continuation of a mobile unit in Vancouver, it was pointed out that the program cost significantly less than treating a person infected with the HIV virus.

2. Treatment and Rehabilitation

The provinces and local communities have the primary responsibility for the development and implementation of drug and alcohol treatment and rehabilitation programs. These programs, which usually address addiction to alcohol and drugs together, include detoxification, early identification and intervention and assessment and referral, basic counselling, therapeutic interventions, clinical follow-up and some workplace initiatives.

Under the Drug Strategy, federal funding was committed to provinces and territories to increase the availability of alcohol and drug treatment and rehabilitation programs. In 1988, cost-sharing agreements to provide $70 million over five years were established under the

authority of the *National Health and Welfare Act*. Women and young people were among the groups to be targeted.

Treatment centres with specific programs for women are a relatively new phenomenon. People who work in the field suggest that women are more likely to hide their substance abuse problems for fear of stigmatization or lest they might have to give up their children. In 1994, the Canadian Public Health Association developed a video on women and substance use for health and social service providers; it emphasizes the links between substance use and sexual health, mental health and violence. At the community level, groups like that at the Pictou County Women's Centre in New Glasgow, Nova Scotia offer assistance to women and their families.

Young substance abusers need residential treatment centres and outpatient programs that are open at all times of the day and in many settings. In 1991, plans were made to establish the first residential addiction treatment centre for young people in Ottawa; at the time it was estimated that the Ontario government was spending approximately $7 million annually to send young people to the United States for treatment. Over and above the amount paid by the province for each young addict, families were spending an average of $4,000 each for transportation and other expenses. The lack of facilities for young solvent abusers in northern Canada has been noted. In mid-1993, it was reported that there were no treatment beds available in the region for 2,200 solvent abusers in northern Manitoba.

Methadone maintenance programs are aimed at helping heroin addicts when other forms of treatment have failed. Under strict medical supervision, addicts, who must participate in mandatory counselling, are administered methadone, a chemical substitute for heroin. In 1993, it was noted that the Ontario government's attempts to reduce costs by restricting counselling hours would harm the work of methadone clinics.

3. Enforcement and Control

At the federal level, various government bodies are involved in detection and enforcement efforts that incur high costs for personnel and equipment. The Ministry of the Solicitor General is the lead department with respect to policing, including the Royal Canadian Mounted Police. The Ministry of National Revenue is responsible for the Customs and Excise Program charged with controlling the movement of certain goods, including tobacco, alcohol and drugs. Both the RCMP and Canada Customs report an increase in drug seizures since the Drug Strategy was implemented.

The failure of past law enforcement efforts to counteract the trade in illegal drugs has led to arguments for decriminalization or the lifting of criminal prohibitions on personal possession of currently prohibited substances. In support of decriminalization it is claimed that present enforcement costs deplete available resources for health-related programs, that violence is produced by the illegal drug trade, and that the treatment for abuse of harmful legal drugs and treatment for use of illegal drugs are inconsistent. Arguments against decriminalization cite the probability that health and social costs would increase if the stigma of drug use were to be removed.

One of the legal concerns with respect to substance abuse is the continued disparity between court sentences. For example, judges can give anything from an absolute discharge to up to seven years' imprisonment for simple possession of cannabis. An Ontario study of possession trials in 18 locales showed discharge to be the outcome in as few as 9% and as many as 75% of cases. The fear is that the present system continues the criminal penalties and social disadvantages resulting from encounters with the legal system yet without evidence that it is a major deterrent. It has been argued that court diversion programs are needed to treat drug users with major psychological or addiction or abuse problems.

Other efforts at control have focused on substance use in the workplace. Employers' concerns have led to various forms of drug testing programs in both the public and private sectors. At the federal level, testing of members of the Canadian Forces began in 1992; in the private sector, companies like Imperial Oil Limited test new employees and employees in

safety-sensitive positions. Both the federal Privacy Commissioner and Human Rights Commissioner have argued that such testing presents problems.

PARLIAMENTARY ACTION

In May 1987, the Minister of National Health and Welfare announced the National Drug Strategy after extensive consultation with provincial and territorial governments, non-governmental organizations and addiction experts.

The House of Commons Standing Committee on National Health and Welfare reported in October 1987 on its inquiry into alcohol and other drug abuse in Canada. The report, entitled *Booze, Pills and Dope: Reducing Substance Abuse in Canada*, supported a balanced approach to reducing substance abuse, one that would combine legal controls with prevention, education and treatment.

In June 1990, the House of Commons Standing Committee on Transportation submitted its review of the government's strategy on prohibiting and preventing substance use by those in safety-sensitive positions in the federal transportation sector. The Committee recommended that any new legislation should provide for alcohol and drug testing in specific job circumstances, such as after an accident, at regular medical examinations, and during applications for employment, rather than at random.

The adverse effects of alcohol abuse on a developing foetus were highlighted in the June 1992 report of the Sub-committee on Health Issues. In its report to the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women, entitled *Foetal Alcohol Syndrome: A Preventable Tragedy*, the Sub-committee stressed the need for increased public attention and research resources. It recommended that warning labels be placed on alcoholic beverages.

In February 1994, the *Controlled Drugs and Substances Act* (Bill C-7) was introduced and received second reading. Like Bill C-85, introduced in the previous Parliament, Bill C-7 sought to amalgamate the 1961 *Narcotic Control Act* and the *Food and Drugs Act* and to bring Canada into conformity with its international obligations under several U.N. Conventions.

After prolonged study by both the House of Commons Standing Committee on Health and the Standing Senate Committee on Legal and Constitutional Affairs, this bill, renamed C-8, received Royal Assent in June 1996.

In its June 1994 report *Toward Zero Consumption: Generic Packaging of Tobacco Products,* the Standing Committee on Health affirmed that plain packaging could be a reasonable step in the overall strategy to reduce tobacco consumption.

Two pieces of legislation that received first reading in the House of Commons in March 1996 address labelling of legal substances; Bill C-24 (a government bill) aims to amend the *Tobacco Products Control Act* provisions on warning labels, while Bill C-222 (a Private Member's bill) seeks to amend the *Food and Drugs Act* to require warnings on alcoholic beverage containers. A Senate (Private Member's) Bill, S-5, also focuses on tobacco.

In May 1996, pursuant to a recommendation from the Subcommittee that had studied Bill C-7 on controlled drugs, the Minister of Health encouraged the House of Commons Standing Committee on Health to review Canada's drug policy. The Committee accepted the Minister's suggestion that the review focus on the demand-reducing component of the existing Canada's Drug Strategy rather than on the supply-reducing component. The specified component falls within the broader concept of "harm reduction" and is focused on education, prevention, treatment and rehabilitation.

CHRONOLOGY

1908 - The *Opium Act* was passed, prohibiting trafficking in opium. This was the first federal legislation on drugs.

1923 - *Cannabis sativa* was added to the controlled drugs under the *Opium and Narcotic Drug Act*.

1935 - Alcoholics Anonymous was established.

1960 - The *Food and Drugs Act*, enacted in 1920, was broadened to include a focus on the non-medical use of LSD, amphetamines, barbiturates, and other drugs.

1961 - Changes were made to the *Narcotic Control Act* and Canada ratified the Single Convention on Narcotic Drugs.

1970 - The Le Dain Commission was established and initiated widespread public discussion of the issues.

1971 - The Non-Medical Use of Drugs Directorate was formed at the Department of National Health and Welfare; this was the first time a single federal agency had assumed responsibility for coordinating research and programs in alcohol and drug dependency.

1973 - The report of the Le Dain Commission (the Commission of Inquiry into the Non-Medical Use of Drugs established in 1970) supported the gradual withdrawal of criminal sanctions against the user along with the parallel development of alternative means to discourage use and reduce harm.

1975 - The Native Alcohol Abuse Program was established to provide support to programs for Treaty Indians.

1987 - The National Drug Strategy, a new federal program to fight drug abuse through prevention and enforcement, was announced.

1987 - The Canadian Coalition on Medication Use and the Elderly, representing 18 national organizations for seniors, health care professionals and the pharmaceutical industry, was formed. It drew attention to drug problems created by over-prescription of the elderly.

1988 - Parliament established the Canadian Centre on Substance Abuse to provide a national focus on alcohol and drug abuse.

1990 - The National Alcohol and Other Drugs Survey, the first comprehensive national compilation of data on drug use, was completed.

1990 - The Minister of Transport proposed a policy on substance use in the workplace that would focus on education of employees, with testing to be limited to specific circumstances, not done at random. The policy would affect four federally regulated transportation sectors: marine, aviation, rail and trucking.

1992 - Canada's Drug Strategy was combined with the Driving While Impaired Strategy and renewed for another five years. Heavier emphasis was placed on prevention of substance abuse and on reduction of harm to users.

1994 - The Tobacco Demand Reduction Strategy, a three-year initiative, was announced.

1995 - After the Supreme Court of Canada on the *RJR-MacDonald Inc.* v. *Attorney General of Canada* struck down five sections of the *Tobacco Products Control Act*, Health Canada responded with its Blueprint document for tobacco control. It provides a general framework for new legislative requirements on areas including advertising, promotion, sponsorship, access, point of sale, packaging and labelling, product regulation and reporting.

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